EAST DALLAS *FAMILY EYE CARE*
8202 Elam Road, Suite #100
Dallas, TX 75217
(214) 391-1119

Welcome to our clinic! We appreciate you choosing our eye care practice for your eye health needs. Please complete this form in its entirety. If you have any questions, please ask us for assistance. ALL OF YOUR INFORMATION WILL BE KEPT CONFIDENTIAL, AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT**.**

PATIENT INFORMATION

Name:____ Date:________________________________
Last First M.I.

Address:____ City,State,Zip:_________________________

Date of Birth: ____________________ Home Phone: ( )____________________

Social Security# _______________________ Work or Cell Phone: ( )__________________

INSURANCE INFORMATION

Name of Primary Medical Insurance:_________________________________

Name of Secondary Medical Insurance:_______________________________

Name of Vision Insurance:____

Name Insurance is Listed Under & that person's Social Security Number:

____

Name of Primary Insured Employer:_________________________________

HEALTH INFORMATION

Were you referred to our clinic by another health care provider? Y N If yes, who?_______________________

Do you currently wear glasses: Y N
Do you currently wear contact lenses: Y N
Interested in contact lenses?: Y N

Last Eye Health Exam:___/___/____ Where?_________________________

Last Medical Exam:___/___/_____ Where?_________________________

Current Medications:____

Drug Allergies:____

Pregnant or Nursing: Y N

History of Eye Surgery: Y N If yes, explain:____

Check all of the following that apply to you:

_____family history of high blood pressure
_____family history of diabetes

_____vision that is more blurry in the morning
_____haloes around points of light
_____light sensitivity
_____headaches
_____history of eye or head injury

_____African-American or Hispanic race
_____have sleep apnea
_____age over 40
_____have diabetes
_____have high blood pressure
____family history of glaucoma
_____on oral steroid medications

_____excessive tearing
_____burning eyes
_____female 45 and over
_____eyes feel like sandpaper
_____feel like something is in eye
_____use Visine, ClearEyes or other over-the-counter drops
_____intolerance of contact lenses
_____fluctuating vision
_____on hormone replacement therapy
_____history of sties

____itchy eyes
____have stringy whitish discharge
____rub eyes a lot
____eyes sometimes red
____watery eyes